Annual Report

Emergency Medical and Trauma Prevention

Fiscal Year 2000

July 1999 - June 2000

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Office of Emergency Medical and Trauma Prevention
Health Systems Quality Assurance Division

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Acknowledgments

This annual report of Emergency Medical and Trauma Prevention summarizes the accomplishments for the fiscal year 2000 (July 1, 1999 through June 30, 2000). These accomplishments are the product of cooperative efforts among advisory committees, the Washington State Department of Health, regional councils, provider groups, other community and state agencies and organizations.

Of Notable Mention

The Emergency Medical Services (EMS) and Trauma Care Steering Committee, which provides guidance and direction to this office;

The Licensing and Certification Committee which advises the Department of Health on administrative rules pertaining to prehospital provider licensing and certification;

The technical advisory committees, which assist the Steering Committee;

The eight EMS and Trauma Care Regional councils:

- Central Region EMS and Trauma Care Council
- East Region EMS and Trauma Care Council
- North Region EMS and Trauma Care Council
- North Central Regional EMS and Trauma Care Council
- Northwest Region EMS and Trauma Care Council
- South Central Region EMS and Trauma Care Council
- Southwest Region EMS and Trauma Care Council
- West Region EMS and Trauma Care Council;

Local EMS and Trauma Care Councils;

The EMS Education Committee and Senior EMS Instructors;

Numerous workgroups for projects such as protocol and examination development, IPPE TAC Statewide Display, etc.;

All of the EMS and Trauma Care providers.

Contents

Executive Summary and Highlights of Fiscal Year 2000

- On June 21, 2000, Tacoma General Hospital and St. Joseph's Medical Center in Tacoma were designated to provide joint, Level II adult trauma care services. This designation represents a significant accomplishment for the citizens of Pierce County, as well as for the state of Washington – geographic completion of the Statewide Trauma System.

- An Emergency Cardiac Technical Advisory Committee (Cardiac TAC) was established and held its first meeting on May 8, 2000. This TAC will assess the current provision of emergency cardiac care in the state and recommend improvements as appropriate or needed. Efforts will include prevention, prehospital care, hospital care, and rehabilitation care.

- The three-year transition process to the new EMT-Basic curriculum was completed and all agencies are operating under its guidelines. All EMT courses taught in Washington are now consistent with the U.S. Department of Transportation EMT-Basic curriculum.

- For fiscal year 2000, 100% of all community based training programs are within a six-mile radius of an EMS provider's licensed/verified agency.

- Based on the 1997 Governor's Executive Order on Regulatory Reform and the Washington Administrative Code requirements, **all** EMS and Trauma Care rules (90 Sections) were reviewed, amended, and adopted in June 2000. This rule review process began in 1997 and an extensive public input process was used.

- Staff traveled to all regions throughout the state, on a quarterly basis, and provided trauma registry data and reports to the regional quality improvement committees. The data focused on highlighting both areas of concern and areas of success. Successes became opportunities to share positive experiences within the region and concerns were opportunities to understand how the system can be improved.

- Regional Quality Assurance and Quality Improvement grants were made available from the Department of Health to each of the regional quality improvement committees to advance and improve the quality improvement process for trauma care.

- Data provided from the Trauma Registry led a number of the regional quality improvement committees to undertake specific efforts to further investigation and prevention efforts regarding water and snow related injuries, and falls among all age groups.

- The Trauma Fund generated and distributed approximately $16 million in the form of grants and enhanced reimbursements to prehospital, hospital, clinical, rehabilitation trauma care providers.

Introduction

Mission

To establish, promote, and maintain a system of effective emergency medical and trauma care services. Such a system provides timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury and recognizes the changing methods and environment for providing optimal emergency care throughout the state of Washington.

Framework

Trauma - the leading cause of death for all people under age 44 and the leading cause of disability for all people under age 65 - is a preventable epidemic in the United States. It is estimated that 30-40 percent of trauma deaths would not occur when an organized trauma system is in place.

The *Washington Emergency Medical Services and Trauma Act of 1990* declared that a trauma care system, one which delivers the "right" patient to the "right" facility in the "right" amount of time, would be cost effective, assure appropriate and adequate care, prevent human suffering and reduce the personal and societal burden resulting from trauma. It requires that the full continuum of care from prevention through prehospital, hospital, and rehabilitation services be implemented statewide.

To fulfill the mandates of this legislation, six major groups have been assembled:

1. The EMS and Trauma Care Steering Committee
2. The Licensing and Certification Advisory Committee
3. The Office of Emergency Medical and Trauma Prevention
4. The EMS Education Committee
5. The eight EMS and Trauma Care Regions
6. The twelve Technical Advisory Committees of the Steering Committee

These six groups are described as follows:

1. The Emergency Medical Services and Trauma Care Steering Committee

The Governor-appointed, EMS and Trauma Steering Care Committee consists of representatives from emergency physicians, surgeons, hospitals, emergency nurses,

prehospital providers, firefighters, local health departments, consumers, and other affected groups. It provides guidance and direction to the state office in its development of the trauma system. It utilizes twelve technical advisory committees (TACs) with over 150 members from various disciplines.

2. The Licensing and Certification Committee

The Licensing and Certification Committee advises the Department on regulation of ambulance and aid services and prehospital provider certification.

3. The Office of Emergency Medical and Trauma Prevention (OEMTP)

The OEMTP consists of four sections: Education, Training and Regional Support; Licensing and Certification; Trauma Designation, Registry and Quality Assurance; and Prevention, Policy and Planning. These sections provide leadership, direction, technical support, system assessment and regulatory enforcement for the system.

4. EMS and Trauma Care Regions

The eight EMS and Trauma Care Regions are made up of local and regional councils. This component of the trauma system represents local interests and helps develop and maintain the system at a grassroots level. The regional councils are supported by grants from the Department of Health and are charged with developing and implementing regional plans and regional patient care procedures. Patient Care Procedures (PCPs) help assure that the "*right*" patient is taken to the "*right*" facility in the "*right*" amount of time.

The regional plans are the cornerstone in the development of the state's emergency medical services and trauma system. They address issues pertaining to demographics, education and training, communication, quality assurance, prevention and public education, prehospital services, acute care and rehabilitation facilities, and patient care procedures.

In short, the regional councils address four fundamental questions:

1. What are the causes of trauma identified by communities within the region?
2. Is trauma care readily available in the regions?
3. Is the system efficient and effective?
4. What is needed to implement and/or improve the system?

5. The EMS Education Committee

The EMS Education Committee advises the OEMTP on education and training standards, conference development, instructor improvements, and curriculum review pertaining to prehospital basic, intermediate, and advanced life support personnel.

6. Technical Advisory Committees (TACs)

The TACs advise the Steering Committee, which advises OEMTP on policies, programs, strategies, emerging issues, and other relevant matters related to the state trauma system. The TACs are:

Cardiac (new in 2000)	Injury Prevention/Public Education
Communications	Pediatric
Cost Reimbursement	Prehospital
Data	Public Policy
Disaster	Regional Advisory
Hospital/Rehabilitation	Resource Allocation

EMS and Trauma Care System Components

The six major components of the EMS and Trauma System are:

1. Injury Prevention and Public Education
2. Human Resources
3. Prehospital Care
4. Definitive Care
5. Evaluation
6. Administration

This annual report provides a brief description of these components and the accomplishments in each area for fiscal year 2000 (July 1, 1999-June 30, 2000).

Injury Prevention and Public Education

The Emergency Medical Services and Trauma System in Washington State has integrated Injury Prevention into its core mission since 1990. Injury Prevention occurs at many levels in Washington State: through statewide programs, through regional and local endeavors, and with both paid and volunteer people who firmly believe that trauma can be prevented, lives can be saved, and disabilities prevented. The trend in unintentional injury fatalities and hospitalizations is generally down. However, there are still hundreds of people who truly do not know what they can do to reduce their risk of injury; lack the financial means to obtain a prevention tool; know they should do something, but still do not. We want Washington to be known as a safe state, where people have a reduced risk for injury.

Prevention of disabling injuries and fatalities is the first component of the trauma system in Washington State. The four "E's" of injury prevention are: ***Education*** *(of the public, policy makers, and health providers about trauma risk reduction);* ***Enforcement*** *(of laws and regulations designed to reduce trauma risk); and* ***Engineering/Environmental changes*** *(of products that are safer and protective, such as cars, helmets, roads, and waterways). The fourth "E" is frequently added to prevention—****EMS/Trauma—****the system that cares for trauma patients in order to reduce the numbers of deaths and levels of disability once a traumatic injury occurs. Prehospital providers have a significant role in all levels of injury prevention because they are called to incidents and know the consequences of fatal and disabling injuries. Many understand that there are ways to prevent such unnecessary tragedies. They are involved in a variety of prevention efforts, including: bicycle helmet and safety promotion, drunk driving prevention, youth suicide prevention, and childhood drowning prevention.*

Primary prevention *works to prevent the incident and resultant injury from happening at all; for example, safe boating or bicycling educational programs.* ***Secondary prevention*** *lessens the impact of a traumatic incident, and increases the likelihood of survival, such as use of seatbelts, bicycle helmets, or life vests.* ***Tertiary prevention*** *alleviates some of the aftereffects of trauma through rapid EMS/Trauma response, transport to the appropriate facility designated to provide*

trauma care services, diagnostic and surgical interventions as needed, and access to rehabilitation services.

Throughout the state, injury prevention strategies are being implemented through the eight EMS/Trauma regions and through Levels I and II trauma services. This year a Trauma Service Coordinator was appointed to the Injury Prevention Public Education TAC to provide liaison between the TAC and the Trauma Nurse Network. Each region has an Injury Prevention Coordinator and an Injury Prevention/Public Education Committee that helps decide what injuries need to be addressed and the most effective strategies to lessen the occurrence of traumatic injuries. The Department of Health staff provides leadership, funding, technical assistance, materials, data, training, and consultation.

2000 Injury Prevention Accomplishments

Sober Roadways for Washington (SRFW): SRFW was presented to at least 8,511 adolescents and adults throughout the state. The SRFW video or slides and speakers were used as stand-alone programs or in conjunction with mock driving under the influence (DUI) crashes and DUI victim impact panels, at alcohol/drug treatment programs and in juvenile detention sites. Well over 3,000 hours of volunteer time was given to staging the mock crashes. They are strong examples of partnerships and collaboration among local agencies, including: EMS, fire, law enforcement, schools, wrecking companies, funeral homes, airlift agencies, and volunteers.

Bicycle Helmets and Safety Promotion: Promotion continues with regions purchasing helmets at a discount through the Washington Trauma Society and distributing them to schoolchildren through many avenues. At least 9,660 helmets were distributed in fiscal year 2000 through the EMS/Trauma system, each with a correct fit session and educational material. While bicycle-related fatalities are relatively rare events, there are many hospitalizations due to bicycle-related crashes. Helmets are known to reduce the risk of brain injury by 88 percent, making them one of the most effective and affordable injury prevention tools that we have.

The Saved By The Helmet Club (SBHC): The SBHC has over 600 members ranging from age 4 to 70. The main source of referrals to the club is hospital emergency departments. Club members are rewarded with a certificate,

T-shirt, water bottle, and pin for using a helmet. The purpose of the club is to acknowledge people who wear bicycle helmets. In so doing, many have become advocates for helmet use and told their stories to schools, families, and friends.

The Tread To Safety Program: The program's goal is to prevent falls among older adults; it has reached over 1,050 seniors in the East and North Central regions. Over 30 volunteers take the presentation to senior centers, retirement homes and senior nutrition sites. Central Region has developed a Falls Factors Program with in-home visits and assessments. People who fall are the target population and the goal is to prevent recurring falls. Falls are the leading cause of injury hospitalization among all ages. Older people are particularly vulnerable because at least 42 percent never return home after breaking a hip.

Pre-conference Trauma Prevention Workshop: The conference was held August 19, 2000, in Spokane and attracted an audience of over 75 people. The keynote speaker was Victor La Cerva, MD, from the New Mexico Department of Health. Dr. La Cerva kept the audience captivated with his talk "World Peace Begins at Home." Breakout sessions were: Child Passenger Safety: Fitting and Using Child Car Seats; Dog Bite Prevention; Equestrian Injury Prevention; Gear Up Games: Hands-on Injury Prevention; and Bicycle Helmet Promotion and Fitting. The last two general sessions were Drug Recognition Expert (DRE) training by the Washington State Patrol and a "how-to" course on Mock DUI Crashes at high schools by East Region staff.

Dozens of exhibitors were invited to display their injury prevention materials, resources, curricula, how-to ideas, props for presenting programs and answer questions. A grand total of fifty-four organizations had exhibits that were staffed and an additional thirty-six provided literature and materials that were made available. Between the injury prevention registrants, people attending the Senior EMT Instructor workshop, school children that volunteered to participate in Gear Up Games and bicycle helmet fitting, hotel staff and guests and others, we estimate that at least 320 people were able to view and learn about a wide variety of injury prevention programs and resources.

Reach Out… With Hope Suicide Prevention Program: Since April 1996, the East Region has trained over thirty volunteers as trainers, who reached 1,934 people this year. These include adolescents and adults. The focus of *Reach Out…With Hope* is to help people understand the signs of pre-suicide ideation and

how to ask someone if they are contemplating suicide or having suicidal thoughts. Presentations are given for prehospital providers, "as continuing medical education" to juvenile justice staff, Native American sites, and for teachers and school staff. Pre- and post-test evaluations indicate an increased comfort level with the topic of suicide and the ability to talk with someone about it.

Statewide Childhood Drowning Prevention Project: This project received new Emergency Medical Service for Children funding in October 1997 for Adolescent Drowning Risk Assessment and Prevention. The focus was on understanding adolescent risk-taking around water and helping regional coalitions develop programs to reduce risk. It was granted a third year to complete evaluation components including: use of life vests in small boats observational survey, risk survey completed by parents of teens who drowned, and to pilot test and complete a middle school curriculum. While funding for regional projects was not available during this year, several continued with life vest loan programs, and public education, using the life vest fashion show to raise awareness about using stylish life vests. The team was also able to update and redistribute the teen media campaign and radio public service announcements that were run during the summer.

Minors in Prevention (MIP): This program was developed and is managed by the East Region. It models the Southwest Advocates for Youth (SWAY) to create positive diversion for first time youthful DUI/drug offenders. MIP uses law enforcement, the medical examiner's/coroner's office, hospital emergency department, ICU, and rehabilitation unit to show youth some of the consequences of drinking and/or drugging and then driving. The youth are court-referred and must report back to the court when they are finished. Volunteer advocates accompany the youth on their program. This fiscal year, 244 youths completed the program. Recidivism rate is very low in SWAY and early data reports the same for the newer MIP program.

Other injury prevention initiatives:

- The teen DUI impact panel in the Northwest Region reached 472 youths and their families' by presentations of DUI victims telling their stories and the negative impact DUI has had on their lives.

- At least a dozen mock DUI crashes were staged at high schools to give a visible and graphic portrayal of what happens in the DUI crash.

- Regional coordinators also participated in planning and implementing several Highway Safety Corridor Projects that target high risk/incident roadways, e.g., Highway 20 in North Region, Highway 97A in North Central Region, the 395 Y in East Region, and the Lower Yakima Valley in South Central Region. Lead agencies for the Corridor Safety Projects are Washington Traffic Safety Commission and Department of Transportation. Significant decreases in motor vehicle-related injuries have been seen in all projects. EMS/Trauma has been involved for several years with the Corridor Safety Projects.

- Child passenger safety is a major issue. The Washington State Legislature passed the Anton Skeen Child Booster Seat Law in early 2000. It was the first booster seat law in the country and takes effect July 1, 2002. At least ten states will consider booster seat legislation in 2001. Public education is being done through the EMS/Trauma system, as well as other organizations, to make sure booster seats are available, affordable, and acceptable to the public. There are booster seat materials and hotlines in several languages, trauma service coordinators received information to use in emergency departments, and a large public information and education campaign will be ongoing. EMS/Trauma Regions, SAFE KIDS Coalitions and others are conducting child car seat checks, fitting and distribution, as well as training people to become certified car seat checkers. Several hundred seats were distributed and many more checked and properly fitted in a vehicle.

- Child Death Review (CDR) Teams were established in most counties. The teams look comprehensively at each unexpected child death from ages zero to eighteen. Regional injury prevention coordinators participate on some of the teams and several other EMS personnel and prevention professionals are regular members of the teams. The CDR process is being used in Washington and other states to determine better prevention strategies. Since many members of teams are not accustomed to thinking in prevention terms, the IPPE TAC, drowning prevention team and others are helping educate CDR teams about prevention and how most injuries can be prevented.

- Program partners in prevention with EMS/Trauma are varied and committed. They include: Harborview Injury Prevention and Research Center, Children's Hospital and Regional Medical Center, the Center for Childhood Safety at Mary Bridge Children's Hospital, Washington Traffic Safety Commission, designated trauma service facilities, local health jurisdictions, federal agencies, Trauma

Nurses Talk Tough, THINK FIRST, Risk Watch, SAFE KIDS, Community Traffic Safety Task Forces, ENCARE (Emergency Nurses Cancel Alcohol-Related Emergencies), local EMS agencies through mini-grant support for prevention projects, and county injury prevention coalitions in some of the more rural counties such as Skamania, Pacific, Wahkiakum, and Lewis.

- Regional IPPE Coordinators participated in a vast array of local and regional community events to promote safety, health, and trauma reduction. Several regions have lending libraries of materials, bicycle rodeo props, displays and other equipment that other community members borrow and use at events.

- Through a grant from Washington Traffic Safety Commission, the Injury Prevention/Public Education Technical Advisory Committee was able to pay for travel and training of its members. This allowed regular training in a variety of injury prevention topics such as: using and fitting child booster seats, life vest fitting, and DUI prevention.

8th Emergency Medical Services and Trauma Legislative Day:
The 8th Annual EMS & Trauma Legislative Day was held on February 28, 2000. This day is used to inform legislators about EMS and trauma issues. It was sponsored by the EMS and Trauma Care Steering Committee, Washington Chapter of the American Trauma Society, Washington State Council of Firefighters, Washington Ambulance Association, Washington State Medical Association and American Medical Response. Thirty exhibitors were showcased in the Capitol Rotunda, eight emergency vehicles were displayed outside the legislative building, and a Washington State Patrol bomb-sniffing dog showed her abilities to about 150 school children. It is estimated that over 1,200 people visited the displays and exhibits throughout the day.

Washington Poison Center: The Poison Center provides statewide 24-hour telephone information to the public and health care providers regarding poisonings and suspected poisonings. It also provides information regarding environmental and toxicological concerns. The center responded to 134,061 phone call requests for help in calendar year 1999, making it one of the busiest centers in the world. The center can provide on-line poison information and first aid intervention in 140 languages. This capability was established through the use of the AT&T language line services.

Human Resources

Human resources include prehospital and hospital personnel who respond to emergency medical and trauma incidents across the state. To ensure optimal care for seriously injured patients, it is necessary to have sufficient numbers of adequately trained emergency medical and trauma personnel available in all areas of the system. This fiscal year, 51 percent of personnel were volunteer providers.

The Education and Training Program, designed to meet the needs of both paid and volunteer prehospital and hospital personnel, involves basic and advanced educational preparation, continuing emergency medical and trauma education, development of educational standards, and the overall quality assurance and/or improvement of prehospital personnel. Emphasis is placed on making the education accessible to rural and volunteer prehospital EMS and Trauma personnel. This has been accomplished through development and administration of community-based training programs that provide continuing medical education to prehospital providers. A concerted effort is made to improve the overall quality of education through assessments, instructor workshops, and training reviews.

2000 Human Resources Accomplishments

Community Based Training (CBT): Accessible education for the rural and volunteer prehospital EMS provider is the goal of CBT. Through outreach programs, such as the Inland Empire Training Council's mobile training program serving the East and North Central Regions, EMS personnel are able to maintain their critical lifesaving skills without leaving their community. For fiscal year 2000, 100 percent of all community based training programs are within a six-mile radius of an EMS provider's licensed/verified agency.

As a result of an active partnership among the OEMTP, licensed EMS agencies and local and regional councils, over 1,511 educational sessions were held, resulting in over 19,733 educational contacts with prehospital providers.

On-Going Training and Evaluation Program (OTEP): The OTEP method of recertification continues to impact all EMS agencies throughout the state. OTEP renewals, after a three-year training cycle, have increased as OTEP continues to meet recertification needs. Staff is available to provide record review and technical assistance to EMS agencies on the evaluation and refinement of OTEPs. To date, nearly 95 percent of all licensed services use OTEP as the primary recertification method.

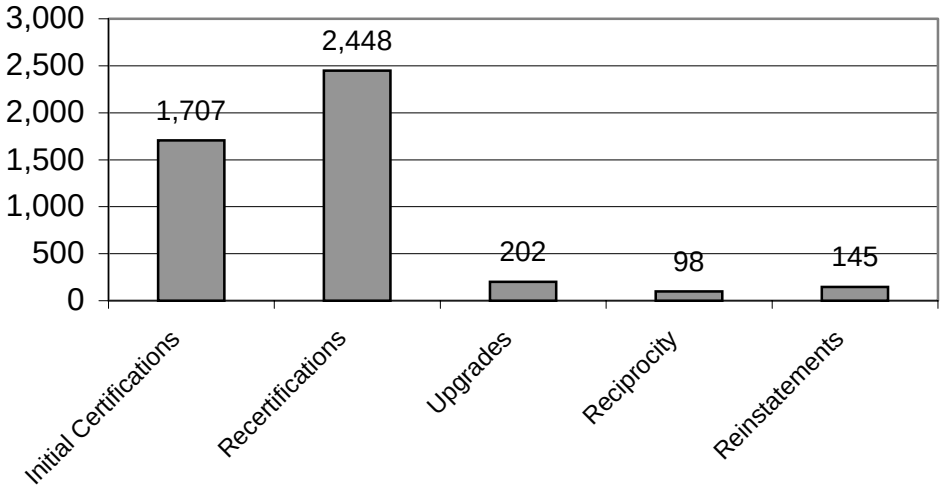
Initial Training: Prehospital providers received initial EMS and Trauma education through approximately 142 training courses. During fiscal year 2000, DOH approved thirty-four first responder courses, ninety-one EMT courses, six IV (intravenous) technician courses, one ILS (intermediate life support) course and five paramedic courses. In addition, approximately thirty-three special skills courses were provided, such as pneumatic anti-shock garment, automatic and manual defibrillation, IV monitor/maintenance and PTL/Combitube.

Initial Training Courses, Fiscal Year 2000

Course	Number	Percent
First Responder	34	24%
EMT	91	64%
IV Tech	6	4%
Airway Tech	0	0%
IV/Airway Tech	0	0%
ILS Tech	1	1%
ILS/Airway Tech	5	4%
Paramedic	5	4%
Total	142	100%

Certification/Recertification: In fiscal year 2000, 1,707 prehospital personnel received initial certification and 2,448 were recertified. In addition, the following were processed: 202 upgrades, 97 reciprocity applications, and 145 reinstatements. These total 5,380 certifications processed. As of October 12, 2000, there were 16,251 certified prehospital providers.

Certification/Recertification - 1999-2000



Education of Providers in Designated Trauma Services: Each Regional EMS/TC Council received $10,000 to support trauma training and education for physicians and nurses in designated trauma services. The courses funded include ACLS, ATLS, and PALS.

EMS-No CPR Program: This program allows EMS personnel to refrain from resuscitating adults, with a physician-signed directive, in the event that the patient suffers a cardiac arrest. This program benefits the terminally ill, individuals with AIDS, Alzheimer's, and other known incurable diseases. During fiscal year 2000, approximately 33,387 EMS-No CPR directives, 15,111 EMS-No CPR bracelets, 530 EMS-No CPR guidelines, and 132 sample informational packets were provided to physicians, hospitals, and intermediate health care facilities.

EMS-No CPR

	Count
Directives	33,387
Bracelets	15,111
Guidelines	530
Information	132

EMT-Basic Curriculum Implementation: The three-year transition process to the new EMT-Basic curriculum has been completed and all agencies are operating under the current EMT-Basic curriculum guidelines. All EMT courses taught in Washington are consistent with the U.S. Department of Transportation EMT-Basic curriculum. The new requirements and skills in the current EMT-Basic curriculum are: CPR prerequisite, refined on-line and off-line MPD direction, increased pharmacology training such as assisting patients with physician-prescribed nitroglycerin, epinephrine auto-injectors and, inhalers.

First Responder Curriculum: The three-year transition training process for the new First Responder curriculum is in its last year. During the transition process veteran First Responders learn new skills, which include auto defibrillation, assessment-based patient evaluation, and use of the bag-valve-mask. Veteran First Responders have until July 1, 2001, to complete continuing medical education in the new areas.

EMT-Intermediate Curriculum: In February 1999, the new EMT-Intermediate Curriculum was completed and made available to communities that have identified a need for intermediate levels of emergency care. This curriculum contains instruction for Intravenous Therapy Technician, Airway Technician, IV and Airway Technician, Intermediate Life Support (ILS) Technician, and ILS and Airway Technician. Staff provide on-site orientations and technical assistance to all approved intermediate program instructors and coordinators. Training effectiveness will be assessed over a three-year period to determine what improvements need to be made to the program.

Paramedic Curriculum: In January 2000, the paramedic curriculum was approved and implemented through approved paramedic training agencies throughout Washington State.

Public Access Defibrillation: The Department of Health developed the "Public Access Defibrillation Training Course Guide and Application Packet" to assist training organizations in obtaining citizen defibrillation course approval. Currently, there are nine approved public access defibrillation training programs in Washington.

Emergency Medical & Trauma Prevention Website: OEMTP hosts an Internet home page (www.doh.wa.gov/hsqa/emtp) designed to give consumers and EMS provider's access to information about the EMS and Trauma System. The home page has links to statutes, rules, curricula, on-line training forms, reports and other information. During the past year the website has been accessed over 6,000 times.

State EMS and Trauma Conference: The 24th Annual Statewide Emergency Medical Services/Trauma Conference was held August 20-22, 1999, at the Spokane Convention Center. This event helps EMS/Trauma personnel gain extended knowledge and continuing medical education credits. Over 450 prehospital providers from around the state attended, and forty vendors had exhibit booths at the conference.

Along with the main conference, the State Instructor Preconference Workshop hosted around 125 Senior EMS Instructors (SEI) and evaluators. EMS instruction information was shared in the form of class motivation, instructor hints, effective presentation strategies, case studies, power point presentations, and moulage ideas. There was also an injury prevention preconference, discussed in the IPPE Section.

Prehospital Care

Prehospital care includes communication systems, EMS medical direction, patient care procedures, triage, and transport. Probably the most readily recognized component of the EMS and Trauma communications system is the 9-1-1 service. Enhanced 9-1-1 is implemented statewide. This system automatically identifies the address of any specific 9-1-1 call received.

One of the more significant aspects of trauma care is the appropriate triaging or "sorting" of trauma patients. A trauma triage tool for use by prehospital personnel has been implemented statewide. This will assure the transport of trauma patients to the appropriate designated facility.

In addition, verification of prehospital services continues. Verified prehospital services are capable of providing the highest level of trauma care. This process assures minimum response times, additional trauma-specific equipment, trauma life support training for all personnel, and capabilities for intermediate and advanced life support care.

2000 Prehospital Care Accomplishments

Licensed & Trauma Verified Agencies:

Licensed & Trauma Verified - In fiscal year 2000 there were 158 licensed and trauma verified ambulance agencies and 304 licensed and trauma verified aid agencies. Together, these agencies include 2,148 licensed and trauma verified vehicles.

Licensed Only – In fiscal year 2000, there were twenty-one ambulance agencies and nineteen aid agencies that were licensed only. Together these agencies include eighty-five licensed vehicles.

Licensed & Verified Agencies

	Ambulance	Aid	Total
Licensed & Verified			
BLS	148	203	351
(Vehicles)	*534*	*772*	*1306*
ILS	5	1	6
(Vehicles)	*11*	*12*	*23*
ALS	5	100	105
(Vehicles)	*493*	*326*	*819*
Licensed Only			
Agencies	21	19	40
(Vehicles)	*33*	*52*	*85*
Total			
Agencies	179	323	502
(Vehicles)	*1071*	*1162*	*2233*

Regional Patient Care Procedures (PCPs): Regional Patient Care Procedures are in place and fully operational in each of the eight EMS and Trauma Care Regions. The procedures help determine how to get the "*right" patient* to the "*right" facility,* in the "*right" amount of time* and are continually evaluated and refined to improve patient care. Regional Patient Care Procedures are developed in much the same way as the Regional EMS/TC Plans: local, county, and regional levels develop the procedures, which are adopted by the regional council for use within the region, then reviewed by the EMS/Trauma Care Steering Committee and approved by the Department of Health. They provide a blueprint and guideline for operation of the entire regional EMS/TC system.

County Operating Procedures (COPs): COPs specify and operationalize prehospital provider agency activities at the county or local level. As a subset of the regional PCPs, these county procedures enable local EMS councils and provider agencies to mutually define agency response areas, provide for effective and efficient system operation, and provide maximum EMS and trauma patient care coverage to the citizens within each county.

The Kristine Kastner Act: During the spring of 1999, a new law entitled the "Kristine Kastner Act" was passed by the Legislature. The law required DOH to conduct a study to determine the rate of anaphylaxis in the state, and to determine the effectiveness of training EMTs to carry and administer epinephrine to persons under the age of thirty who display signs of anaphylaxis. The Act further

required all licensed ambulance and aid services to make epinephrine available to EMTs in their emergency care supplies. Beginning January 2000, DOH is required to allow EMTs to administer Epinephrine to children (under 18) and adults when they have proof of a prescription. OEMTP prepared a report on the rate of anaphylaxis and training effectiveness for submission to the Legislature. The offices also developed the implementation section of the law to meet the above requirement. Evaluation of the program will be in effect until December 31, 2001.

Medical Program Director Workshops: The Office held one Medical Program Director (physician) workshop to discuss and make decisions on training and certification issues.

Examination Development: With assistance from the Licensing and Certification and the Education Committees, staff developed a validated initial certification examination for IV Techs, Airway Techs IV/Airway Techs, ILS Techs, and ILS/Airway Techs. The examinations were developed based on the new EMT-Intermediate curriculum. A psychometrician validated the exam questions.

Definitive Care

Designated trauma services provide definitive care for trauma patients. The care provided at designated facilities includes resuscitation, stabilization, diagnosis, surgery, intensive care, and trauma rehabilitation.

There are multiple levels and categories of designated trauma services. All levels play a vital role in the state trauma system. The levels differ from each other in the types of services offered and standards for services, staffing, response times, equipment, and training.

Levels range from Level I trauma services, with capabilities to care for the most severely injured patients, to Level V trauma services, which resuscitate, stabilize and transfer patients to a higher level of care. Designation of Level V trauma services recognizes the vital role of the rural medical clinic and hospital in trauma care. There are also three levels of pediatric trauma service designation and four levels of trauma rehabilitation designation. Washington's standards for trauma services are a modification of the American College of Surgeons' Resources for Optimal Care of the Injured Patient. Integrating trauma rehabilitation and the creation of Level V trauma service standards are notable innovations of the Washington State system.

Each regional EMS/TC council recommends the minimum and maximum number and level by category of designated trauma services needed to provide appropriate coverage in the region. The recommendations are based on unique needs in each region including patient volumes, each healthcare facility's commitment to provide trauma services, and existing resources. The EMS and Trauma Care Steering Committee reviews these regional recommendations and recommends to DOH regarding the minimum and maximum numbers within each region. DOH has the final responsibility for determining the minimum and maximum numbers of trauma services to be designated at each level in each category for each region and for the state as a whole.

Hospitals and other healthcare facilities apply for trauma service designation every three years. DOH awards designation to the most qualified applicants within the maximum numbers in the approved regional and state plans. All written applications receive a thorough administrative review by DOH staff. Hospitals applying for Level I – III trauma service and pediatric trauma service designation also receive an on-site review by a team of trauma experts prior to designation. Level IV and V trauma services may receive a similar on-site review during their period of designation.

2000 Definitive Care Accomplishments

Tacoma Trauma Service: On June 21, 2000, Tacoma General Hospital and St. Joseph's Medical Center in Tacoma were designated to provide joint Level II adult trauma care services. At the same time, Madigan Army Medical Center was officially recognized by DOH as meeting all designation requirements. This designation represents a significant accomplishment for the citizens of Pierce County as well as for the State of Washington – geographic completion of the Statewide Trauma System.

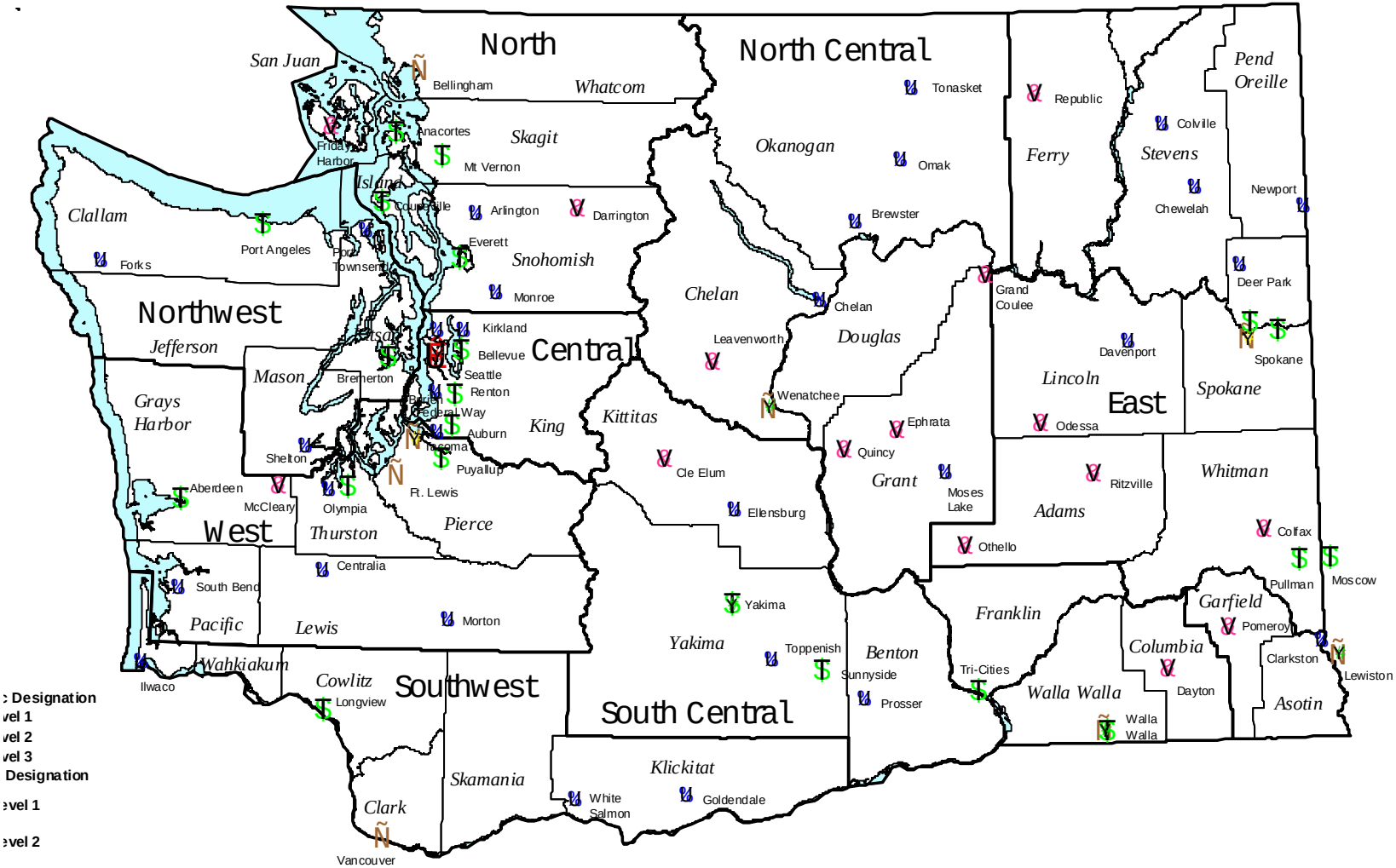
Trauma Rehabilitation Designation: OEMTP completed initial round of trauma rehabilitation service designation. As of June 30, 2000, there were twenty-two facilities providing designated trauma rehabilitation services.

Designation of Acute Care Services: OEMTP completed the second round of trauma service designation. Twenty-six health care facilities were re-designated to provide trauma services in fiscal year 1999. As of June 30, 1999, there were seventy-nine facilities providing designated trauma care services

On-Site Reviews: Using teams of experts, on-site reviews were conducted at seventeen hospitals applying for Level I, II, or III trauma service designation or pediatric trauma service designation.

The following maps indicate the physical location of the designated trauma care services in the state of Washington. The first map shows the locations of the designated acute care services. The second map shows the locations of the designated trauma rehabilitation services.

Washington State
Designated Trauma Care Services



Washington State Department of Health
Office of Emergency Medical & Trauma Prevention
(360) 705-6700 or 1-800-458-5281

Washington State Designated Trauma Care Services

June 21, 2000

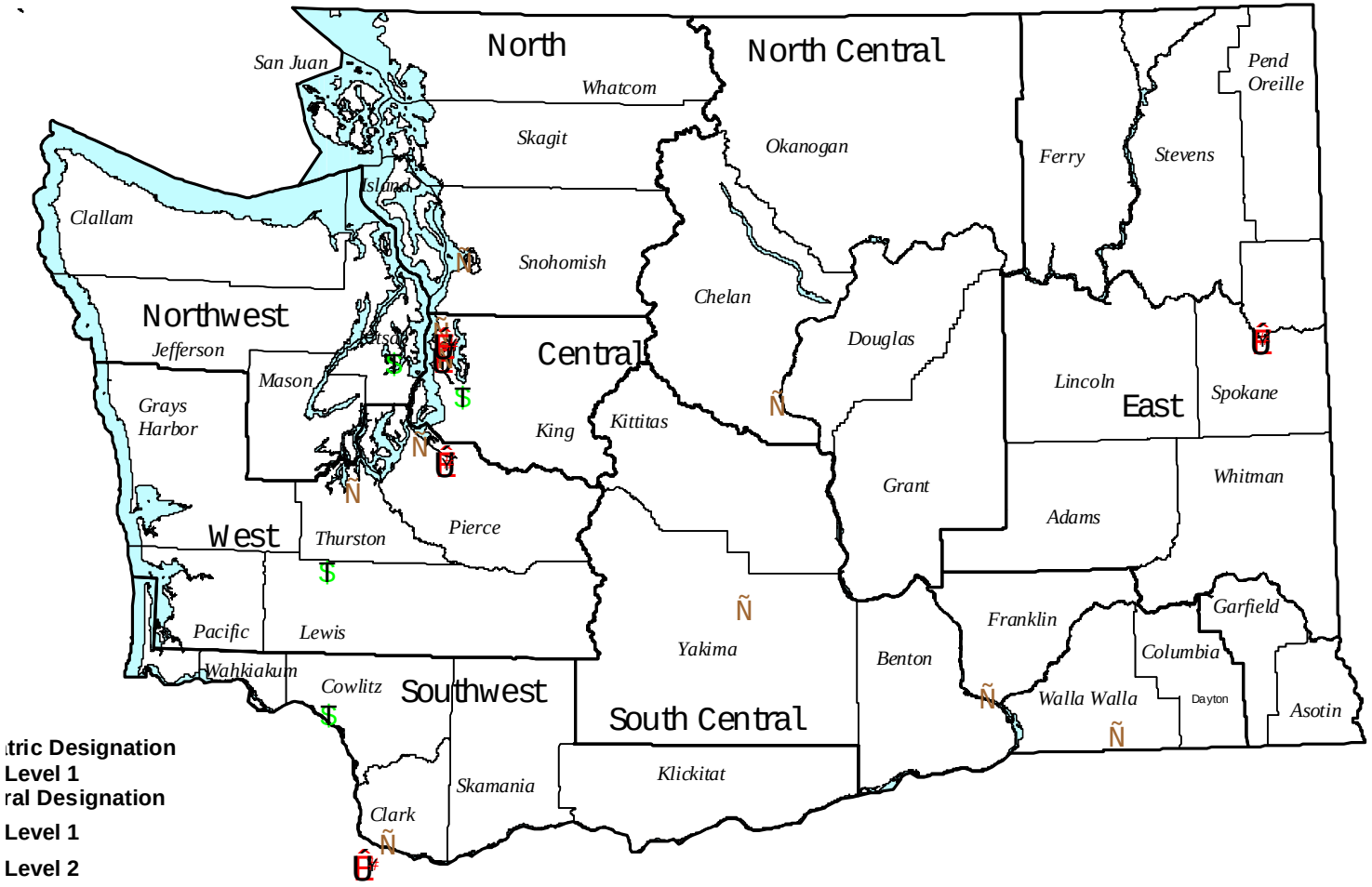
	Designated Level			
Statewide	I	I-P	Harborview Medical Center	Seattle
Central Region	III		Auburn General Hospital	Auburn
	III		Overlake Hospital Medical Center	Bellevue
	III		Valley Medical Center	Renton
	IV		Evergreen Hospital Medical Center	Kirkland
	IV		Highline Community Hospital	Burien
	IV		Northwest Hospital	Seattle
	IV		St Francis Community Hospital	Federal Way
East Region	II	II-P	Spokane Joint Trauma Services Deaconess Medical Center & Sacred Heart Medical Center	Spokane
	II	III-P	St Joseph Regional Medical Center	Lewiston, Idaho
	III		Gritman Medical Center	Moscow, Idaho
	III		Holy Family Hospital	Spokane
	III		Pullman Memorial Hospital	Pullman
	III		Valley Hospital & Medical Center	Spokane
	IV		Deer Park Health Center & Hospital	Deer Park
	IV		Lincoln Hospital	Davenport
	IV		Mount Carmel Hospital	Colville
	IV		Newport Community Hospital	Newport
	IV		St Joseph's Hospital of Chewelah	Chewelah
	IV		Tri-State Memorial Hospital	Clarkston
	V		East Adams Rural Hospital	Ritzville
	V		Ferry County Memorial Hospital	Republic
	V		Garfield County Hospital District	Pomeroy
	V		Odessa Memorial Hospital	Odessa
	V		Othello Community Hospital	Othello
	V		Whitman Hospital and Medical Center	Colfax
North Region	II		St Joseph Hospital	Bellingham
	III		Island Hospital	Anacortes
	III		Providence General Medical Center	Everett
	III		Skagit Valley Hospital	Mt Vernon
	III		Whidbey General Hospital	Coupeville
	IV		Cascade Valley Hospital	Arlington
	IV		Valley General Hospital	Monroe
	V		Darrington Clinic	Darrington
	V		Inter-Island Medical Center	Friday Harbor
North Central Region	II	III-P	Central Washington Hospital	Wenatchee
	IV		Lake Chelan Community Hospital	Chelan
	IV		Mid-Valley Hospital	Omak
	IV		North Valley Hospital	Tonasket
	IV		Okanogan-Douglas County Hospital	Brewster

	IV		Samaritan Hospital	Moses Lake
	V		Cascade Medical Center	Leavenworth
	V		Columbia Basin Hospital	Ephrata
	V		Coulee Community Hospital	Grand Coulee
	V		Quincy Valley Hospital	Quincy
Northwest Region	III		Harrison Memorial Hospital	Bremerton
	III		Olympic Memorial Hospital	Port Angeles
	IV		Forks Community Hospital	Forks
	IV		Jefferson General Hospital	Port Townsend
	IV		Mason General Hospital	Shelton
South Central Region	II	III-P	St Mary Medical Center	Walla Walla
	III		Sunnyside Community Hospital	Sunnyside
	III		Tri-Cities Trauma Service Kadlec Medical Center, Kennewick General Hospital & Lourdes Medical Center	Tri-Cities
	III		Walla Walla General Hospital	Walla Walla
	III	III-P	Yakima Valley Trauma Service Providence Yakima Medical Center & Yakima Valley Memorial Hospital	Yakima
	IV		Kittitas Valley Community Hospital	Ellensburg
	IV		Prosser Memorial Hospital	Prosser
	IV		Providence Toppenish Hospital	Toppenish
	V		Dayton General Hospital	Dayton
	V		Kittitas County Hospital District #2	Cle Elum
Southwest Region	II		Southwest Washington Medical Center	Vancouver
	III		St John Medical Center	Longview
	IV		Klickitat Valley Hospital	Goldendale
	IV		Ocean Beach Hospital	Ilwaco
	IV		Skyline Hospital	White Salmon
West Region	II		Madigan Army Medical Center	Fort Lewis
	II		Tacoma Trauma Center-Adult Services St. Joseph Medical Center & Tacoma General Hospital	Tacoma
	III		Good Samaritan Community Healthcare	Puyallup
	III		Grays Harbor Community Hospital	Aberdeen
	III		Providence St Peter Hospital	Olympia
	IV		Capital Medical Center	Olympia
	IV		Lewis County Hospital District #1	Morton
	IV		Providence Centralia Hospital	Centralia
	IV		Willapa Harbor Hospital	South Bend
	V		Mark Reed Hospital	McCleary
		II-P	Mary Bridge Children's Hospital	Tacoma

P = Pediatric Trauma Service

There are currently 82 designated acute care trauma services, 7 of which provide definitive pediatric trauma care.

Washington State
Designated Trauma Care Rehab Services



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Washington State Designated Rehabilitation Trauma Care Services

The following facilities were designated to provide trauma care rehabilitation services as of June 30, 2000:

Region	Designation		Facility	City
Statewide Resources	I-R		HMC/UWMC Trauma Rehabilitation Service Harborview Medical Center, University of Washington Medical Center	Seattle
		I-RP	Children's Hospital & Regional Medical Center	Seattle
	I-R	I-RP	Heath Rehabilitation Center at Good Samaritan Hospital	Puyallup
	I-R		Legacy Rehabilitation Services, Rehabilitation Institute of Oregon	Portland
		I-RP	Legacy Emanuel Children's Hospital, Pediatric Development & Rehabilitation	Portland
	I-R	I-RP	St Luke's Rehabilitation Institute	Spokane
Central	I-R		HMC/UWMC Trauma Rehabilitation Service Harborview Medical Center, University of Washington Medical Center	Seattle
		I-RP	Children's Hospital & Regional Medical Center	Seattle
	II-R		Northwest Hospital Rehabilitation Unit	Seattle
	II-R		Providence Seattle Medical Center Comprehensive Acute Rehabilitation Unit	Seattle
	III-R		Valley Medical Center Rehabilitation Services	Renton
East	I-R	I-RP	St Luke's Rehabilitation Institute	Spokane
North	II-R		Providence General Medical Center Rehabilitation Services	Everett
North Central	II-R		Cascade Medical Center	Wenatchee
Northwest	III-R		Green Mountain Rehabilitation Medicine	Bremerton
South Central	II-R		Turning Point Rehabilitation at St Mary Medical Center	Walla Walla
	II-R		Lourdes Medical Center Inpatient Rehabilitation Unit	Pasco
	II-R		Providence Yakima Medical Center Rehabilitation Unit	Yakima
Southwest	I-R		Legacy Rehabilitation Services, Rehabilitation Institute of Oregon	Portland
		I-RP	Legacy Emanuel Children's Hospital, Pediatric Development & Rehabilitation	Portland
	II-R		Southwest Washington Medical Center	Vancouver
	III-R		St John Medical Center	Longview
West	I-R	I-RP	Heath Rehabilitation Center at Good Samaritan Hospital	Puyallup
	II-R		St Joseph Medical Center Inpatient Rehabilitation	Tacoma
	II-R		Providence St Peter Hospital Medical Rehabilitation Program	Olympia
	III-R		Providence Centralia Hospital	Centralia
Total	18	4		

R = Trauma Rehabilitation Care P = Pediatric

Regional Quality Improvement Programs

The eight ongoing EMS/TC Regional Quality Improvement (QI) Programs continue to provide ongoing and objective evaluation of system issues. Issues and concerns evaluated and discussed relate to the delivery of care by verified prehospital agencies and designated trauma care services. In accordance with statute and regulations, the QI programs are sponsored and led by the Level I, II, or III services in each region, with additional support and assistance from OEMTP. Each of the regional QI committees has its own OEMTP-approved organizational and operational plan that provides a structure for regular activities. Meetings are held at least quarterly. Any concerns, problems, and/or recommendations for system improvements that these QI programs identify may be forwarded to Regional EMS/TC councils and/or OEMTP for further consideration. Sharing of "lessons learned" is a major benefit of the QI process. Other significant benefits are an increased awareness of the capabilities and components of the regional trauma system, recognition of community and regional issues, and the significance of trauma registry data elements.

OEMTP supports the regional QI activities by:

- *Providing regional and statewide data from the Washington Trauma Registry.*
- *Providing ongoing consultation and technical assistance.*
- *Sponsoring workshops and symposia with local and national QI leaders and researchers.*

Regional Quality Improvement Accomplishments: Programs have been initiated in all regions of the state, and all eight of the programs have organizational and operational plans that are formally approved. Each region's quality assurance program meets on at least a quarterly basis. The goal of these programs is an ongoing and objective evaluation of system issues surrounding the delivery of regional trauma care by verified prehospital agencies and designated trauma care services. Any identified concerns, problems, and recommendations are referred to the regional EMS and Trauma council or the OEMTP for action.

Evaluation

Evaluation includes data collection, system assessment, and quality assurance. Implementation of the Washington Trauma Registry is underway. It will provide comprehensive information on all major trauma patients from the site of injury through prehospital, acute, and rehabilitative care. Linking of patient records across the continuum of care is a unique and innovative aspect of the Washington Trauma Registry, which will allow us to examine the contribution each phase of care makes to the patient's outcome.

The Trauma Registry provides detailed information about a narrowly defined set of patients—those who were critically injured—where improvements to the EMS and Trauma System can make the most dramatic improvements in care. The Trauma Registry supports rational and unbiased review and revision of the system of trauma care, based on factual data rather than impressions and traditions.

Regional trauma care quality improvement programs are under the direction of designated Level I, II, and III trauma care services in each region and include support and participation from OEMTP. The Trauma Registry will be a key element in support of these activities. Overall design of the EMS and Trauma Care System involves a broad range of participants including EMS and Trauma Care Councils, regional QI programs, EMS providers, the Department of Health, and many others.

One of the current focuses is to assess and ensure the completeness of the data from healthcare facilities, and to develop strategies that will assure accurate and complete collection of data from designated health care facilities and verified prehospital agencies. Part of this effort may involve some of the regions in data collection and analysis activities.

2000 Evaluation Accomplishments

Data Collection: The Department was very active in the collection of data from trauma services and prehospital agencies, with a focus on improving compliance with Prehospital submissions. Some regions participated in data collection and several regions developed comprehensive data collection programs. These programs involved identifying

data collection needs and resources, designing a system to collect and report data to the Washington Trauma Registry, and building a regional data resource.

Approximately 200 people attended sixteen Collector software-training sessions throughout the state. Two scheduled training sessions were offered in each region. In addition, as much as 150 hours of on-site consultation was provided to designated trauma services and trauma verified prehospital agencies. Over 700 hours of technical support was provided via telephone and e-mail by staff in the OEMTP.

The following tables summarize recent trauma registry submission activity:

	FY 1997	FY 1998	FY 1999	FY 2000
Number's of verified EMS transporting agencies	206	237	238	241
Percent of verified EMS transporting agencies submitting	10.4%	19.4%	22.4%	26.1%
Number of designated trauma services	77	79	82	82
Percent of designated trauma services submitting	83.1%	92.2%	92.2%	100%

Trauma Registry Reports: Data from the Trauma Registry supports a variety of programs within the office and in the trauma provider community. Office staff provide trauma registry reports to the Regional Quality Improvement Programs to assist with evaluation of system concerns. Registry reports focusing on a variety of issues are presented to the EMS/Trauma Care Steering Committee at their bi-monthly meetings. Registry staff also provide ad hoc reports to trauma providers and others in response to specific requests, concerns, and special studies.

Administration

Administration includes leadership, system development, legislation, and finance for the statewide EMS and Trauma Care System.

Leadership for the EMS and Trauma Care System comes from the EMS and Trauma Care Steering Committee, the EMS and Trauma Licensing and Certification Advisory Committee, the advisory committees, the EMS and Trauma Care councils, and the OEMTP. Each has specific statutory requirements for developing the system.

System Development consists of planning and implementing the EMS and Trauma Care System as outlined in each of the regional plans. It is a grassroots process that begins at the local level and proceeds through counties, regions, and the state, an approach designed to build consensus and a sense of ownership. Regional plans are the foundation of the system. OEMTP and the EMS and Trauma Care Steering Committee review these regional plans every two years and ask the regions to amend their plans as required. OEMTP formally adopts the regional plans, which are the overall guidelines for implementing the system at the local level. A statewide EMS and Trauma Plan is then developed based upon the approval of the content of these regional plans and incorporation of minimum/maximum numbers for verified prehospital agencies and designated services.

Legislation affecting EMS and trauma is comprised of five separate statutes:

1. *RCW 18.71 sets standards and regulates certification of advanced life support (ALS) and intermediate life support (ILS) personnel, and defines the duties and responsibilities of the Medical Program Directors (MPDs);*
2. *RCW 18.73 sets standards to regulate basic life support (BLS) personnel, and to license prehospital services and vehicles;*
3. *RCW 18.76 establishes poison information centers;*
4. *RCW 70.168 is the Washington EMS and Trauma Act of 1990, which created the trauma system; and*
5. *RCW 70.122 is the Natural Death Act, which included a requirement for establishing guidelines for EMS personnel when responding to patients who have requested to not be resuscitated.*

Financing of the development, implementation, and administration of the EMS and Trauma System comes from many sources. At the state level, designation management, communication system development, prevention, regional, state planning and the Trauma Registry are supported through the state general fund.

This fund also supports the purchase of emergency equipment for EMS and trauma regions and local/regional projects. Community-based training, licensure, and certification of EMS providers and agencies are funded through General Funds State. The Poison Center is funded through General Funds State.

At the local level, trauma services are supported through local and county taxes, special EMS levies, third-party payer reimbursement, and state and federal grants. Local providers are required to match state grant funds for equipment purchases.

The Trauma Care Reimbursement Fund, created in 1997 by the Washington State Legislature, established dedicated funding through the Trauma Care Services Fund Act. This fund is intended to compensate trauma care providers for the unreimbursed care of trauma patients. The source of funding is a $5 surcharge on all moving violations and $4 of a $6.50 fee on the sale or lease of a new or used vehicle (the other $2.50 is an administrative fee for auto dealers). Fund collection began January 1, 1998. It generates approximately $24 million per biennium. Recipients of these funds include (1) verified prehospital agencies, (2) designated trauma care services, (3) physicians/clinicians providing trauma care at a designated service, and (4) designated trauma rehabilitation services.

1. ***Prehospital*** *– Trauma verified prehospital providers receive funds through participation grants and needs grants.*
1. ***Hospital*** *– Trauma designated acute care hospitals receive participation grants and enhanced reimbursement for DSHS Medicaid eligible patients.*
2. ***Physician/Clinician*** *– Physicians and clinicians who provide trauma care at designated trauma services can receive reimbursement at an enhanced rate for treatment of Medicaid eligible patients and will be able to access a "payer-of-last-resort" fund category for care provided where no reimbursement source exits.*
3. ***Rehabilitation*** *– Trauma designated rehabilitation services receive support from the trauma fund through participation grants.*

To ensure that the fund is operating efficiently and appropriately, educational workshops, surveys, payment monitoring, and committee evaluations are conducted on an ongoing basis.

2000 Administration Accomplishments

Technical Assistance: Staff provided guidance and technical assistance to local and regional councils, Medical Program Directors, fire, EMS, and hospital officials in the development and implementation of regional EMS and trauma care plans, regional patient care procedures, regional contracts and several other issues, including the ones identified below. Technical assistance is provided via email, telephone, and through onsite visits and meetings.

***Regional EMS and Trauma Care Contracts*:** Contracts between the eight Regional EMS and Trauma Care councils and the Department of Health were developed for Fiscal Year 2001. Funds were distributed equitably among all the regions, with additional funds available for special injury prevention grants.

Programs and activities conducted through the contracts are vital to continue the implementation and improvement of the statewide system. These include:

- Reassessment of regional training, regional patient care procedures, and prehospital EMS and trauma services;
- Provision of training for EMS personnel;
- Coordination and implementation of injury prevention programs, such as *Sober Roadways* (anti-drunk driving), *Reach Out… with Hope* (suicide prevention), and *Minors In Prevention* (diversion for first time youthful alcohol and other drug offenders);
- Promotion and use of definitive care.

Trauma Fund Billing Workshops: Responding to requests from the field, OEMTP staff conducted educational workshops at the local level for trauma services personnel and trauma physicians and clinicians. The workshops assisted these providers in understanding the billing process for enhanced trauma reimbursement through the trauma care reimbursement fund. Some 145 people attended from Eastern and Western Washington. Of these, seventy-three represented physician/clinician groups, seventy represented trauma services and two represented other entities. In the future, staff plans to conduct targeted workshops in areas of the state where trauma services accessing enhanced reimbursements.

Process Improvements: In an effort to more easily explain how regional support personnel work with local and regional personnel to develop and implement a

statewide EMS and Trauma Care System, a number of processes have been developed. These processes have been designed in a flow chart format to clarify how the grassroots input follows through to an approved document by the Department. These processes currently cover all aspects of the regional plans, minimum/maximum services, PCPs, budgets, contracts, and updates to each of these areas. It is expected that additional processes may be necessary as the system continues to be implemented.

Rule Review: In 1996 OEMTP began a comprehensive review of the trauma system rules (Washington Administrative Code [WAC] Chapter 246-976). This review was initiated by both its own WAC requirement and by the Regulatory Fairness Act of 1995. In 1997, Governor Locke issued Executive Order 97-02, Regulatory Improvement, to help govern how regulations are to be reviewed. OEMTP elected to review and revise the WAC by related sections, rather than as a whole, to more efficiently complete the reviews. The Department uses a negotiated rule making process when reviewing and revising rules. This process depends on significant involvement of individuals and organizations affected by the rules and working closely with staff to develop the least intrusive rules that will still support the standards of the EMS/Trauma system.

In March 1998, the revised Trauma Service Designation rules (WAC 246-976-485 through -890) went into effect, as did the new Emergency Medical Services and Trauma Care Systems Trust Account rules (WAC 246-976-935).

In April 2000, the remainder of the trauma system rules, referred to as the "EMS" rules (WAC 246-976-001 through – 450 and – 910, except 935), were amended and went into effect in May 2000. These rules (training, certification, licensure, verification, trauma registry, and system administration) were revised to address: 1) educational inconsistencies in the curriculum between the various personnel levels; 2) updates to the curriculum; 3) updates to certification requirements; 4) updates to the trauma registry and system administration requirements and responsibilities, and 5) improvements to the structure, grammar, and organization of the WAC, while removing any unnecessary repetition.

At this time, an entire comprehensive review of the trauma system rules has been completed. As required in the WAC, rules, policies and standards will be reviewed at least every four years.

Governor Appointed EMS and Trauma Care Steering Committee

(Current as of December 1, 2000)

Juris Macs, MD, Chair	American College of Surgeons
Lori Taylor, RN, Vice-Chair	Critical Care Nurses Association
*Merry Alto, MD	American College of Emergency Physicians
Robert Berschauer	Washington Ambulance Association
David Byrnes	Washington Association of Fire Chiefs
Michael Copass, MD	Washington State Medical Association
Sue Dietrich, RN	Washington State Medical Association Auxiliary
Bill Hinkle	Local Government Agency Representative
Brian Hurley	Washington State Council of Fire Fighters
David E. Jaffe	Washington State Hospital Association
Eric P. Jensen	Washington State Hospital Association
Bobby F. Kirk	Washington Association of Fire Chiefs
Ronald Maier, MD	American College of Surgeons
*Cynthia Markus, MD	American College of Emergency Physicians
Jim Nania, MD	American College of Emergency Physicians
Elli Nelson	Rural Volunteer, Grant County FD #10
Lothar Pinkers, MD	Washington State Medical Association
Jack Pinza	Prehospital Providers
Zachary Rinderer, RN	Washington State Emergency Nurses Association
Sam Sharar, MD	Washington State Society of Anesthesiologists
Captain Helmut Steele	Law Enforcement
Michael Sumner	Consumer Representative
Margaret Sweasy, RN	NW Association of Rehabilitative Facilities
Kim Marie Thorburn, MD, MPH	Local Health Officials
Salud Villas, RN	Association of Rehabilitation Nurses
Marvin Wayne, MD	American College of Emergency Physicians
David Williams	Washington Fire Commissioners
*Paul Zaveruha, MD, FACS	Medical Program Director

*New members

Licensing and Certification Advisory Committee

Ted Rail, Chair	Washington State Council of Fire Fighters
Geri Chumley	Intermediates, Grant County FD #8
Nina Conn	Local EMS Administration
Scott Edminster, MD	Physicians
David Hammers	Washington State Association of Fire Chiefs
James Pierce	Paramedics
Jack Pinza	Governor's EMS/TC Steering Committee
Mike Turay	Washington Ambulance Association
Lynn Wittwer, MD	American College of Emergency Physicians

Regional EMS/Trauma Care Councils

Central Region EMS & Trauma Care Council, **Michael Copass**, **MD** Chair
East Region EMS & Trauma Care Regional Council, **Kenny Karnes**, Chair
North Central Regional EMS & Trauma Care Regional Council, **Craig Hutson**, Chair
North Region EMS & Trauma Care Regional Council, **Roger Meyers**, Chair
Northwest Region EMS & Trauma Care Regional Council, **Tim McKern**, Chair
South Central Region EMS & Trauma Care Regional Council, **Jon McFarland**, Chair
Southwest Region EMS & Trauma Care Regional Council, **Fred Johnson**, Chair
West Region EMS & Trauma Care Regional Council, **Dave Crawford**, Chair

EMS Education Committee

Jeanne O'Brien, Chair	Tacoma Fire Department
James Dow, Vice Chair	Northwest Region EMS & Trauma Care Council
Don Andres	South Central Region EMS & Trauma Care Council
Paul Berlin	West Region EMS & Trauma Care Council
Terry Cockrum	Southwest Region EMS & Trauma Care Council
Patty Courson	South Central Region EMS & Trauma Care Council
Cindy Hambly	West Region EMS & Trauma Care Council
Larry Herberholz	Washington Fire Chief's Association
Ralph Herth	Northwest Region EMS & Trauma Care Council
Brian Hurley	Washington State Council of Firefighters
Craig Hutson	North Central Regional EMS & Trauma Care Council
Earl Klinefelter	North Region EMS & Trauma Care Council
Richard Kness	East Region EMS & Trauma Care Council
Tim McKern	Washington State Firefighters Association
James Palmer	East Region EMS & Trauma Care Council
Richard Paris	North Central Regional EMS & Trauma Care Council
Larry Reese	Southwest Region EMS & Trauma Care Council
Larry Wall	North Region EMS & Trauma Care Council
Roy Waugh	Central Region EMS & Trauma Care Council
Tracey White	Central Region EMS & Trauma Care Council

EMS Education Committee - At Large Members

Geri Chumley	Licensing & Certification Committee Liaison
Ken Karnes	East Region EMS & Trauma Care Council
Bill Klein	West Region EMS & Trauma Care Council
Norma Pancake	Pierce County EMS
Melody Westmoreland	American Medical Response

Office of Emergency Medical and Trauma Prevention

(Current as of February 2001)

Director:

Janet Griffith

Section Managers:

Rick Buell, Education, Training & Regional Support
Jack Cvitanovic, Licensing & Certification
Dolly Fernandes, Prevention, Policy, & Planning
Kathy Schmitt, Trauma Designation, Registry & Quality Assurance
Sandra Dlugosz, Operations Mangaer

Staff:

Richard Benjamin, Eastern Washington Regional Administrator
Irene Bergsagel, Program Specialist
Christopher Blake, Policy Consultant
Steve Bowman, Research & Data Analysis
Kristi Bullock, Central Support
Ted Dale, Central Support
Neil Edgin, Licensing & Certification Program Specialist
Don Fernandes, Trauma Registry Manager
Norm Fjosee, Western Washington Regional Administrator
Debra Ann Galvan, Training Information Coordinator
Scott Hogan, Regional Quality Improvement
Dane Kessler, Education & Training Specialist
Tom Kimzey, Training Specialist
Julie Kitten, Licensing & Certification Western Washington Supervisor
Susie Leland, Director's Assistant, Secretary Supervisor
Julie Miracle, Budget & Contracts Manager
Kelly Murr, Licensing & Certification Coordinator
Kristin Reichl, Prevention, Policy & Planning Coordinator
Mary Rotert, Health Nurse Consultant
Shane Sanderson, Trauma Registry
Tami Schweppe, Regulatory Reform
Mary Small, Central Support
Mike Smith, Licensing & Certification Eastern Washington Supervisor
Karen Stricklett, Licensing & Certification Program Specialist
Marc Tafoya, Trauma Registry Technical Support
Mickey Wardell, Designation Coordinator
Chris Williams, Senior Health Planner
Kathy Williams, Injury Prevention Specialist